SUGGESTED FORM

Mental Retardation Community Medicaid Services

____ NEW
FOR CSP YEAR

____ REVISION
FOR CSP YEAR

Agency-Directed Companion Services

INDIVIDUAL SERVICE PLAN

ESTIMATED DURATION:_____ Code #: _____

Individual: _____ Medicaid Number:_____

Provider Name:_____Provider Number:_____

Responsible Staff (name or position of implementer of the plan):_____

Start Date:_____ End Date:_____ Quarterly Review Dates: _____ _____ _____ _____

Goals/objectives are based on up-to-date assessment information present in the file.

CSP SELECTED GOAL/ DESIRED OUTCOME:

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

TOTAL HRS PER WEEK:_____		

Individual:_____ Service: **AGENCY-DIRECTED COMPANION** Start Date:_____

TOTAL HOURS PER WEEK

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

NOTE: This service is limited to 8 hours/day, including combinations of Agency-Directed Companion and Consumer-Directed Companion services.

COMMENTS:
(Role of other agencies if plan a shared responsibility)

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*